**New Patient Information Form**

Welcome to our practice! We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and is accurate. Could you please assist us by completing the following information.

|  |  |
| --- | --- |
| Title (please circle) | Dr. Mr. Mrs. Ms. Miss Mast Other: |
| Surname |  |
| Given Names |  |
| Birth Sex (please circle) | Male Female Other: Prefer not to disclose |
| Gender (please circle) | Male Female Other: Prefer not to disclose |
| Date of Birth |  |
| Country of Birth |   |
| Do you identify as (please circle): Aboriginal origin? Torres Strait Islander origin?  |
| Street Address |  Suburb: Postcode:  |
| Postal Address  |  |
| Home Phone Number |  | Work Phone Number |  |
| Mobile |  |
| Email |  |
| Occupation |  |
| Do you consent to receiving text messages? | Yes No |
| Medicare Details | Card No.: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Ref No: Exp.: |
| DVA Number |  White Gold Card No.: Exp.: |
| Pension Number | Card No.: Exp.: |
| Next of Kin | Name: Relationship:Contact Number:  |
| Emergency Contact | Name: Relationship:Contact Number: |
| Payer of Account for Child Under 17yrs | Name: Date of Birth:Medicare Card #: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Ref No: Exp:Relationship:  |
| How did you hear about Lighthouse GP? |



**Patient Medical Health History**

**Name: DOB:**

To assist us with ensuring that your medical record is accurate, please complete the following medical questionnaire.

|  |
| --- |
| **Significant Medical History**Please list any significant medical history such as chronic diseases, surgical procedures, mental health conditions, and other health conditions. |
| **Current Medication**Please list ALL tablets, patches, inhalers, gels, creams, injections, supplements, or homeopathic remedies you currently take or use. |
| **Name of Medication** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
| **Allergies**Do you have any allergies or sensitivities to any medications or fibre materials? **Yes/No** ­­If Yes, Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Smoking History (please circle)**Do you currently smoke cigarettes: Yes No Previous cigarette usage: Year started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If Yes, how many cigarettes per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year stopped: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Alcohol (please circle)**Do you currently consume alcohol: Yes No Past alcohol intake: Year started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If Yes, how many days per week: \_\_\_\_\_\_\_\_\_\_\_\_\_ Year stopped: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many units per sitting: \_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Family History**Does anyone in your family have a history of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** |  | **Who** | **Condition** |  | **Who** |
| Diabetes | Yes No  |  | Psychiatric | Yes No |  |
| Blood Pressure | Yes No  |  | Bleeding | Yes No  |  |
| Heart Disease | Yes No  |  | Asthma | Yes No  |  |
| Stroke | Yes No  |  | Cancer | Yes No  |  |
| Other | Yes No  |  |

 |
| Mother alive? | Yes No | Age of Death: | Cause: |
| Father alive? | Yes No | Age of Death: | Cause: |
| **For Women only**When was the approximate date of your last Cervical Screening (Pap Smear)?  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |